Montgomery HOSPICE

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Lynn Bonde, Executive Director
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Dear Lynn:

Thank you for providing me with the notes from the CON Task Force meeting on June 23. As a hospice administrator who has worked for hospices in three states (MD, MA, and SC), I am sending this letter to address some of the issues raised about hospice at that meeting.

1. There is recent evidence that increased competition does not improve access to quality hospice care. According to a 2004 research study conducted by Yale University, terminally ill patients who receive end-of-life care from for-profit hospices receive a full range of services only half the time compared with patients treated by non-profit hospices. Since for-profit hospices account for almost all of the growth in hospices nationwide (according to the GAO 2000 publication, "Medicare: More Beneficiaries Use Hospice, but for Fewer Days of Care), allowing more hospices to enter a market where the demand is already met will NOT improve access to quality hospice care. This demonstrates that the current hospice CON regulation does provide assurance that dying Marylanders will have access to the entire spectrum of hospice care.

In addition, there is already substantial competition in Maryland's urban areas. For example, in Montgomery County there are seven hospices. The number of deaths in the county has been about 5500 per year for the past several years. If every death had been served by one of the County's hospices (an impossibility because of sudden deaths and people dying who do NOT want hospice care), each hospice would have cared for about 800 patients a year. With a mean length of stay of thirty-five days, the average daily census for each of the seven hospices would be 75 patients. With a mean

length of stay of 10 days, the average daily census would be about 25 patients.

The financial breakeven for hospice care is an average daily census (ADC) of 130-150 patients. This is because almost all of hospice patients' bills are paid by Medicare or by Medicaid and insurance companies that match Medicare rates. Medicare pays a daily reimbursement, that is set this year at $120/day*, no matter what services the patient and family need. The reimbursement methodology uses a bell-curve rationale. Unfortunately, there are many patients that will cost more than $120/day and relatively few that will cost less. Therefore, the expensive outliers will create a loss, but not if the hospice has a high enough number of patients. The industry norm is a breakeven of 130-150 patients. Clearly, even a 75 patient ADC, which is 55-75 patients per day less than breakeven, is not financially sustainable.

*The Medicare rates are set without regard to the number of hospices serving a community. Having greater competition does not lower the price of hospice.

2. The following is an example of what happened in a state (South Carolina) without hospice CON: In the early 1990's there were two hospices in Greenville, SC (pop. 350,000). The hospices, which were affiliated with the city's two non-profit hospitals, were thriving, dynamic hospices. By 1996, there were 13 hospices, half of which were for-profit, serving Greenville. All the hospices were weak, and the two original hospices, that had been delivering excellent, comprehensive care, were forced to cut back on services.

3. The Maryland HealthCare Commission recommended in 2001 that hospice CON should remain in effect. Since there have been no changes in medical practice or mortality and morbidity since then, the same rationale applies today.

Sincerely,

Ann Mitchell

Ann Mitchell MPH
President & CEO